

TO HOSPITAL may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13638

CERTIFICATE OF DEATH

13612

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		b. COUNTY <i>Prince George</i>	
c. LENGTH OF STAY IN 1b <i>32 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		d. STREET ADDRESS <i>16 X-2</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Andrew</i>	Middle <i>D</i>	Last <i>Baden</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>2</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/24/1914</i>
9. AGE (In years last birthday) <i>56 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>State Road Employee</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Equip. Operator</i>	12. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Halbert Baden</i>	14. MOTHER'S MAIDEN NAME <i>Lucy Murphy</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mabel Baden</i>	Address <i>Brandywine, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Ca. of Rectum -</i> (c) <i>Abdomino-pelvic Resection on 11/17/60</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11-7 1960</i> , to <i>12-1 1960</i> , that (I) (we) last saw the deceased alive on <i>12-1 1960</i> , and that death occurred at <i>11-7 1960</i> M, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>R. de Villarreal MD</i>		22b. DATE SIGNED <i>12/1/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>R de VILLARREAL MD</i>		22d. ADDRESS <i>St. Leonard</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-5-60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		23d. LOCATION (City, town, or county) <i>WALDORF, MD.</i>	
ADDRESS		25a. REC'D BY REGISTRAR DATE <i>DEC 6 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13639 CERTIFICATE OF DEATH

Reg. Dist. No.

13613

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		b. COUNTY <i>Calvert</i>	
c. LENGTH OF STAY IN 1b <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Lawrence</i>	Middle <i>Pandle</i>	Last <i>Gray</i>	4. DATE OF DEATH <i>Dec. 15 1960</i>	Month <i>Dec.</i>	Day <i>15</i>	Year <i>1960</i>
-------------------------------------	--------------------------	-------------------------	---------------------	---	----------------------	------------------	---------------------

5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 15 1869</i>	9. AGE (In years lost birthday) <i>91 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>	13. IF UNDER 24 HRS. Min. <i>—</i>
-----------------------	-------------------------------	---	---	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
---	--	--	---

13. FATHER'S NAME <i>Lafayette Broome Gray</i>	14. MOTHER'S MAIDEN NAME <i>Christiana Bowen</i>
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>217-36-844</i>	17. INFORMANT <i>Lyttleton L. Gray, Prince Frederick Md.</i>	Address <i>—</i>
--	--	---	---------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Block - Adams Stokes</i>		<i>1959</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) Alveascelitis C. V. Disease</i>		<i>—</i>
DUE TO (c) <i>Uremia</i>		<i>12/5/60</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>Dec.</i>	Year <i>1960</i>

20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
--	--	---------------------------------	----------------------	---------------------

21. I certify that I attended the deceased from <i>Dec 14 1960</i> to <i>Dec 15 1960</i> , that I last saw the deceased alive on <i>Dec 14 1960</i> , and that death occurred at <i>—</i> from the causes and on the date stated above.

ADDRESS (Street, city or town, state) <i>Prince Frederick 13/16/60</i>	DATE SIGNED <i>—</i>
---	-------------------------

ACTUAL SIGNATURE <i>Page C Jett</i>	M.D.
--	------

PHYSICIAN'S NAME (Type) <i>Page C Jett</i>	PRINCE FREDERICK
---	------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 18, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Central Cemetery</i>	22d. LOCATION (City, town, or county) <i>Barstow Calvert Co., Md.</i>
--	--	---	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>G. A. Haskins Son, Mutual, Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 21 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>
---	---------------------	--	--

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13614

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE							
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. Beach		b. COUNTY Calv.							
c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chest. Beach							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) H. Lat. Park, Park, Ave		d. STREET ADDRESS 1200 Park Ave							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle						
4. DATE OF DEATH		Month	Day						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Type writer		10b. KIND OF BUSINESS OR INDUSTRY Gov.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Harry Griffith		14. MOTHER'S MAIDEN NAME Cora Louise Ward							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT 705-10-9035, Mrs Cora Lacy					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Strangulation from hanging							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Suicide							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hitting the walk for Ward							
20c. TIME OF INJURY Hour o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1200 Park Ave		20f. (City or town) Owings			
20g. (County) Md.						(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE H. W. Ward									
EXAMINER'S NAME (Type) H. W. WARD									
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED 12-12-60									
220. BURIAL, CREMATION, REMOVAL (Specify) Burial 12-16-60		22b. DATE THEREOF 12-16-60		22c. NAME OF CEMETERY OR Crematory Mt Harmony		22d. LOCATION (City, town, or county) Owings			
(State) Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home		ADDRESS Owings		24a. REC'D BY REGISTRAR DEC 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13641 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13615**

1. PLACE OF DEATH a. COUNTY Collected MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Collected	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarendon		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Holmes		First Hol	Middle l
4. DATE OF DEATH Month 12 Day 16 Year 1960		5. SEX M	6. COLOR OR RACE C
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1890	
9. AGE (in years from birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 782		10b. KIND OF BUSINESS OR INDUSTRY 782	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? John Sanders	
13. FATHER'S NAME John Sanders		14. MOTHER'S MAIDEN NAME Mosie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 134-18-1234	
17. INFORMANT John W. Ward		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Condition DUE TO 782 Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO cause lost. _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Did not die at 7:15 am in bed	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) in bed	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Clarendon		(County) Baltimore (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE H. W. Ward		DATE SIGNED 12/16/60	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION, REMOVAL (Specify) 12-19-60		22b. DATE THEREOF 12-19-60	
22c. NAME OF CEMETERY OR CREMATORIAL Moses		22d. LOCATION (City, town, or county) AA and	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell, Jr. and Fred		ADDRESS 12-19-60	
24a. REC'D BY REGISTRAR DATE DEC 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH CERTIFICATE
NUMBER: 1234567890

STATE

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145

100 112 123 145
100 112 123 145
100 112 123 145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 13616

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 13616

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olivett, md.</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olivett, md.</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Rosie</i>	Middle <i>a.</i>	Lost <i>Gross</i>	4. DATE OF DEATH <i>12 11 1960</i>	Month <i>12</i>	Day <i>11</i>	Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 1878 82</i>		9. AGE (In years lost birthday) yrs. <i>82</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Matthew Sutton</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Buck</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Colonel Gross, Olivett, md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>		DUE TO <i>CEREBRAL SCAROSIS</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i>		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Prince Frederick</i>		(County) <i>Prince Frederick</i>	(State) <i>md.</i>
21. I certify that I attended the deceased from <i>Dec. 6</i> , 19 <i>60</i> , to <i>Dec. 11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Dec. 2</i> , 19 <i>60</i> , and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Prince Frederick, md.</i>		DATE SIGNED <i>12/12/60</i>	
ACTUAL SIGNATURE <i>Page C. Jett</i>									
PHYSICIAN'S NAME (Type) <i>Page C. Jett</i>									
22a. BURIAL/CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <i>12-18-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Eastern Chapel</i>		22d. LOCATION (City, town, or county) <i>Olivett, Cal. md.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Seewell, Prince Fred.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 22 60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Morris</i>			

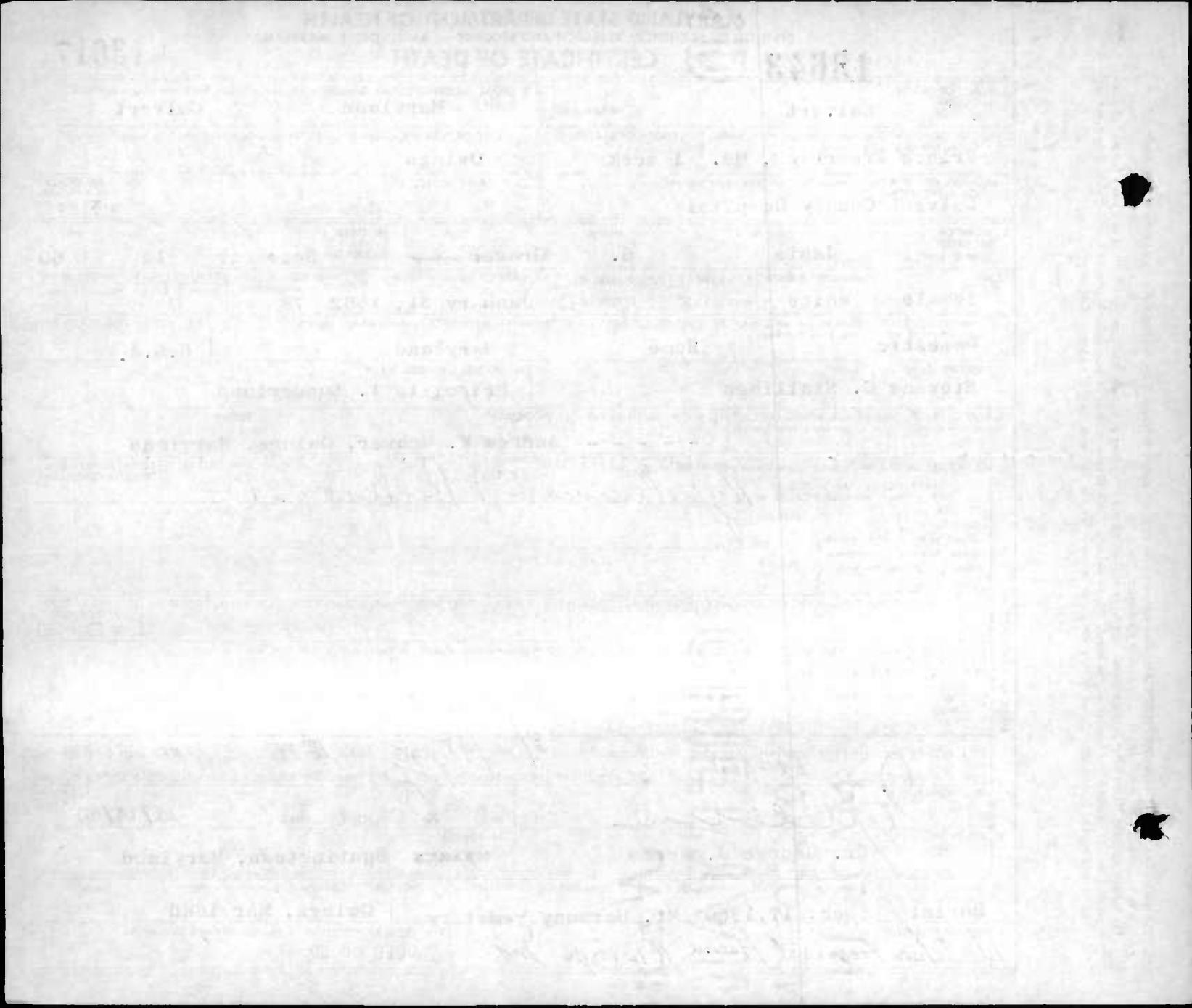
TO HOSPITAL may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13617

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Janie	Middle S.	Last Grover
4. DATE OF DEATH	Month December	Day 14	Year 19 60
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1882
9. AGE (In years last birthday) 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Stevens G. Stallings	14. MOTHER'S MAIDEN NAME Priscilla T. Sunderland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	17. INFORMANT - - - - -	Address Andrew W. Grover, Owings, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V.R. disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/4/48-3/19 to 11/14 , 1960, that (I) (we) last saw the deceased alive on 12/14 1960, and that death occurred at Owings , M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. George J. Weems		22b. DATE SIGNED 11/14/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Owings Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 17, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Harmony Cemetery	23d. LOCATION (City, town, or county) Owings, Maryland (State)
24. FUNERAL DIRECTOR'S SIGNATURE Hutchison Funeral Home Owings Md.		25a. ADDRESS	25b. REC'D BY REGISTRAR DATE DEC 20 '60
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG277 12-27-60 et

Reg. Dist. No. 13618

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co Hospital</i>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles B HANNON</i>		4. DATE OF DEATH Last <i>12</i> Month <i>12</i> Day <i>10</i> Year <i>1960</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <i>Single</i>		8. DATE OF BIRTH <i>12/10/67</i>	
9. AGE (In years last birthday) <i>93</i> yrs.		10. IF UNDER 1 YEAR Months <i>93</i> Days <i>0</i>	
11. BIRTHPLACE (State or foreign country) <i>Charlottesville, Md.</i>		12. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
13. FATHER'S NAME <i>Charles E. Hannon</i>		14. MOTHER'S MAIDEN NAME <i>Sarah (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Hospital Director</i>		Address <i>Calvert County Hospital</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>904</i> DUE TO <i>Calvert varicella and sinus &</i> INTERVAL BETWEEN ONSET AND DEATH <i>2</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Fractions big 13 day ago</i> DUE TO <i>Fall</i> (c) <i>10 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fall and fractures of skull</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fall in really loose Calvert Md</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>11</i> p. m. <i>12/27/60</i>		20d. INJURY OCCURRED <i>White Not white at work</i> <input type="checkbox"/> <i>at work</i> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Prison Calvert Calvert</i> (County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspectian <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <i>12/10/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/16/1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Bumpy Oak Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pomonkey, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arehart Funeral Home, Inc. - La Plata, Md.</i>		ADDRESS <i>1020 20th St. S.E.</i>	
24a. REC'D BY REGISTRAR <i>REC'D 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>John S. K. Smith</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13619

1. PLACE OF DEATH a. COUNTY CALVERT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY CALVERT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK		c. LENGTH OF STAY IN 1b 6 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK (RURAL)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CALVERT COUNTY HOSPITAL		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAURICE	Middle E. HUTCHINS	Last	4. DATE OF DEATH	Month DEC.	Day 8	Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 5, 1903	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) CALVERT COUNTY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY HUTCHINS		14. MOTHER'S MAIDEN NAME VIRGINIA CRAWFORD		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT HAZEL HUTCHINS - PR. FREDERICK			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PERFORATED GASTRIC ULCER 48 hours CORTISONE THERAPY 1 year for RHEUMATOID ARTHRITIS 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 6 , 19 60 , to Dec 8 , 19 60 , that I last saw the deceased alive on Dec 8 , 19 60 , and that death occurred at 315 M, from the causes and on the date stated above. ACTUAL SIGNATURE Page S. Jett M.D. Prince Frederick 12/9/60 DATE SIGNED PHYSICIAN'S NAME (Type) Page S. Jett PRINCE FREDERICK, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 11, 1960		22c. NAME OF CEMETERY OR CREMATORIUM ASBURY CEMETERY		22d. LOCATION (City, town, or county) BARSTOW - CALVERT CO - MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE G. A. Harkness & Son - Mutual, Inc.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harkness	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13646

CERTIFICATE OF DEATH

Reg. Dist. No.

13620

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bushy</i>		d. STREET ADDRESS <i>Bushy</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Robert</i>	Middle <i>C</i>	Last <i>Johnson</i>	4. DATE OF DEATH <i>12-24-1960</i>	Month	Day	Year
--	------------------------	--------------------	------------------------	---------------------------------------	-------	-----	------

5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 3, 1888</i>	9. AGE (In years last birthday) <i>41 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
--------------------	------------------------------	---	---	---	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
---	-----------------------------------	--	--

13. FATHER'S NAME <i>William J. Johnson</i>	14. MOTHER'S MAIDEN NAME <i>Priscilla Johnson</i>
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>111-11-1111</i>	17. INFORMANT <i>Mary E. Johnson, Bushy, MD.</i>	Address
---	---	---	---------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
---	--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
---	--	--	--	--	---	--	--

21. I certify that I attended the deceased from <i>12-10-60</i> to <i>12-24-60</i> , that I last saw the deceased alive on <i>12-25-60</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.			ADDRESS (Street, city or town, state)	DATE SIGNED
---	--	--	---------------------------------------	-------------

ACTUAL SIGNATURE <i>S. J. Weems</i>	M.D.	
--	------	--

PHYSICIAN'S NAME (Type)	
-------------------------	--

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-28-60</i>	22b. DATE THEREOF <i>12-28-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns</i>	22d. LOCATION (City, town, or county) (State)
--	--------------------------------------	--	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell, Prince Frederick</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>
--	---------	---	---

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13621

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Calvert</i>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Victoria</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>																	
3. NAME OF DECEASED (Type or print) <i>Victoria</i>		4. DATE OF DEATH Month <i>12</i> Day <i>25</i> Year <i>1980</i>		5. SEX <i>F</i>		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/28/1892</i>		9. AGE (In years last birthday) 90 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wife</i>		11. KIND OF BUSINESS OR INDUSTRY <i>md</i>		12. BIRTHPLACE (State or foreign country) <i>Md</i>		13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
14. FATHER'S NAME <i>Bud Jones</i>		15. MOTHER'S MAIDEN NAME <i>Princess Jones</i>		16. SOCIAL SECURITY NO. <i>Address</i>		17. INFORMANT <i>Princess Jones</i>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>age</i>		Cardio vascular cerebral disease		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Died at home 150pm</i>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>fall</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12/27/80</i>															
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																					
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>12-28-60 mt. hope</i>		22b. DATE THEREOF <i>12-28-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>mt. hope</i>		22d. LOCATION (City, town, or county) <i>Sunderland, Md</i>															
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. E. Sewell, Prince Frederick</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hayes</i>															

1961 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13648

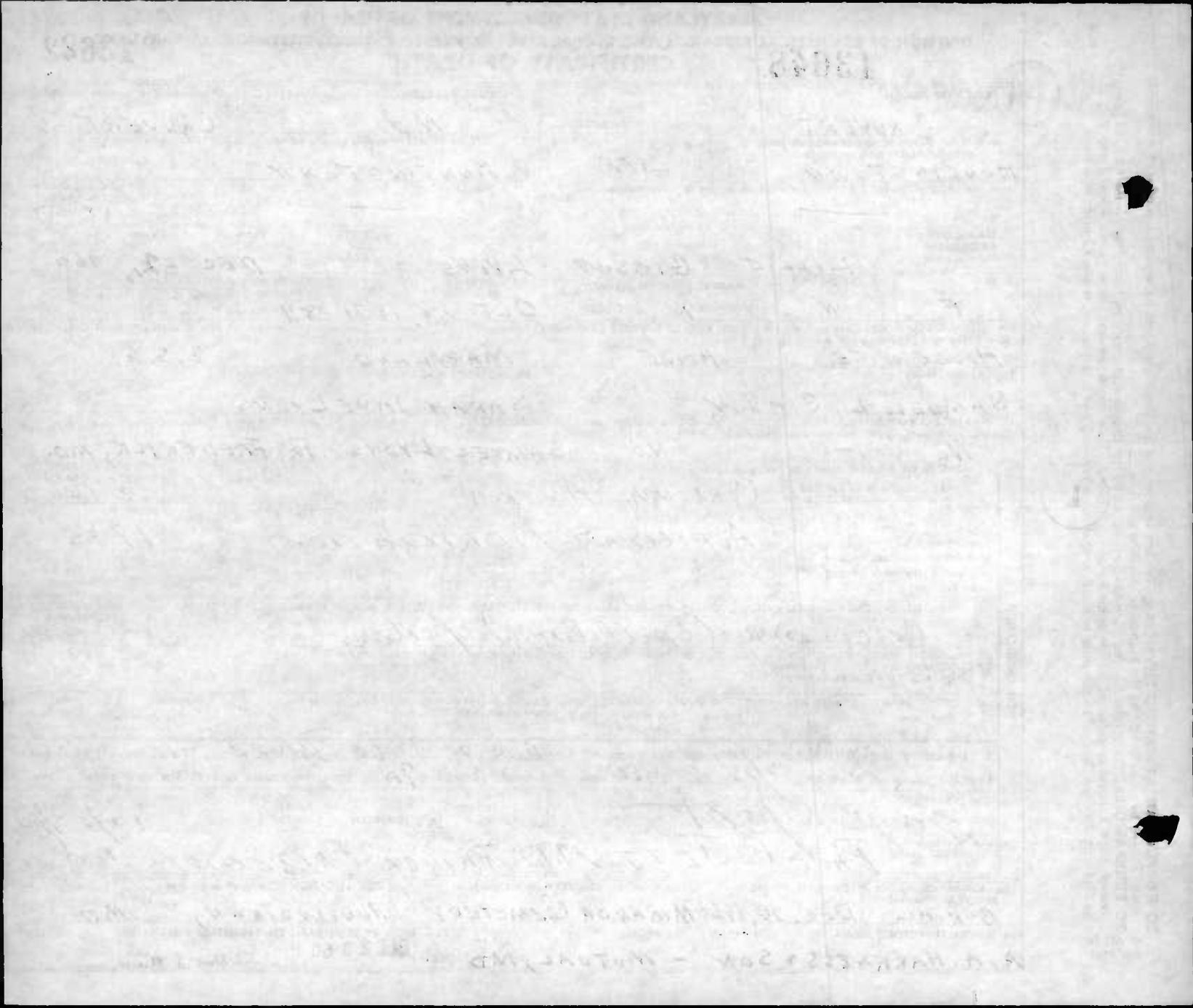
LAND
13622

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
CALVERT		c. LENGTH OF STAY IN lb		a. STATE		b. COUNTY					
HUNTINGTOWN		LIFE		MD.		CALVERT					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		X HUNTINGTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
LILLIE GIBSON				LYONS	DEC. 22	1960					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
F		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	OCT. 24 1871	89 yrs.	Months	Days	Hours	Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
HOUSEWIFE		HOME		MARYLAND		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT			
SAMUEL L. GIBSON		SARAH JANE LYONS		(Yes, no, or unknown) (If yes give war or date of service)				Address			
No		NO		SAMUEL LYONS - Pa. FREDERICK, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 weeks									
433-1 CEREBRAL ANOXIA											
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		1935									
(b) AURICULAR FIBRILLATION											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED?									
Carcinoma (Epithelioma) of nose		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1960 to Dec. 22, 1960, that (I) (we) last saw the deceased alive on Dec. 18, 1960, and that death occurred at 9 A.M. from the causes and on the date stated above.											
22a. SIGNATURE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
PAGE C. JETT M.D.								12/23/60			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		PRINCE FREDERICK MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)			
BURIAL		DEC. 26, 1960		MIRANDA CEMETERY		HUNTINGTOWN, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25e. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
A. A. HARKNESS & SON - MUTUAL, MD.				DEC 28 '60		Arthur S. Thomas					



TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13649 13623

1. PLACE OF DEATH a. COUNTY		Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Md.		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lusby			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		14 days		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Mary Mabel				Pardoe	December	14	1960		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 10, 1891	69 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
House work			Home			Md.			21.5.A
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Reverdy Jones					Mary Monnett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
					17. INFORMANT				
					James W. Pardoe				
					Lusby, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
332X <i>Heart failure due to cerebral thrombosis; enlargement of heart</i>									
INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO (b) <i>thrombosis; enlargement of heart</i>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.				19	While at work <input type="checkbox"/> at work <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from 12/15 1960, to 12/14 1960, that (I) (we) last saw the deceased alive on 12/14 1960, and that death occurred at 12/14 M, from the causes and on the date stated above.									
22a. SIGNATURE					M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)					12/15/60				
Roberto De Villarreal, M.D.					St. Leonard, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town, or county)		(State)	
Burial		Dec. 17, 1960		Middleham Chapel Cemetery		Lusby Calvert Co.		Md.	
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR				
A. G. Harkness & Son, Mutual, Md.					25b. REGISTRAR'S SIGNATURE				
					Calvert S. Harkness				

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

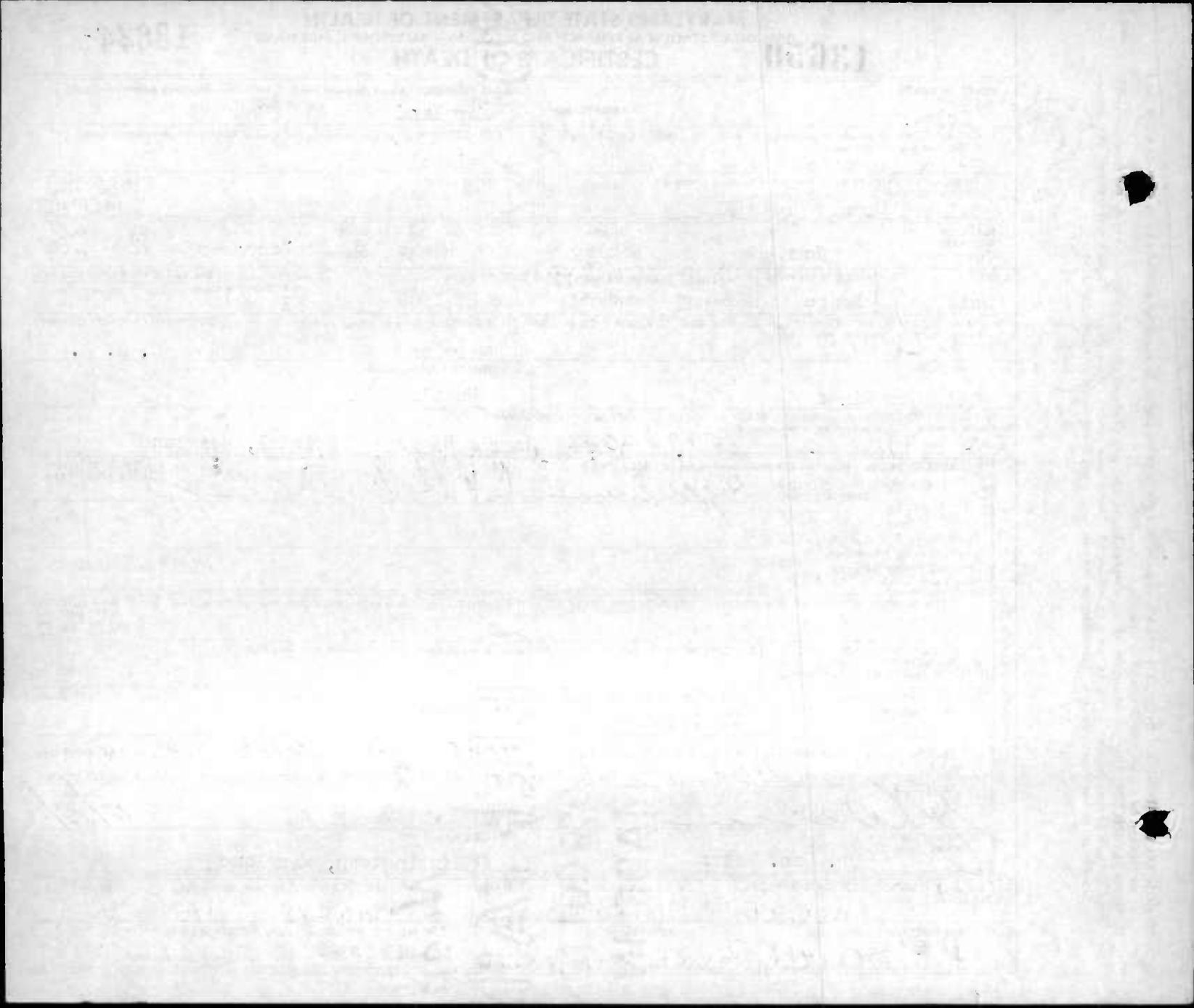
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~corporate~~ papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13624

1. PLACE OF DEATH a. COUNTY Calvert			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle Wesley	Last Riggs	4. DATE OF DEATH Month December
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27 1909	9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Columbus Riggs			14. MOTHER'S MAIDEN NAME Hattie Hall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 579 22 0452		
17. INFORMANT Carrie Riggs			Address Bristol, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO 445X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15 1960 to 12/22 1960 , that (I) (we) last saw the deceased alive on 12/22 1960 , and that death occurred at 4:45 PM , from the causes and on the date stated above.					
22a. SIGNATURE Geo. Weems			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12/23/60		
22c. PHYSICIAN'S NAME (Type) Dr. Geo. Weems			22d. ADDRESS Huntingtown, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Wes. 210, 60 Union Chapel		23b. DATE THEREOF Dec. 21, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Tracy's	
23d. LOCATION (City, town, or county) Tracy's		23e. (State) MD			
24. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell, Prince Frederick,			25a. REC'D BY REGISTRAR DATE DEC 29 1960		
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

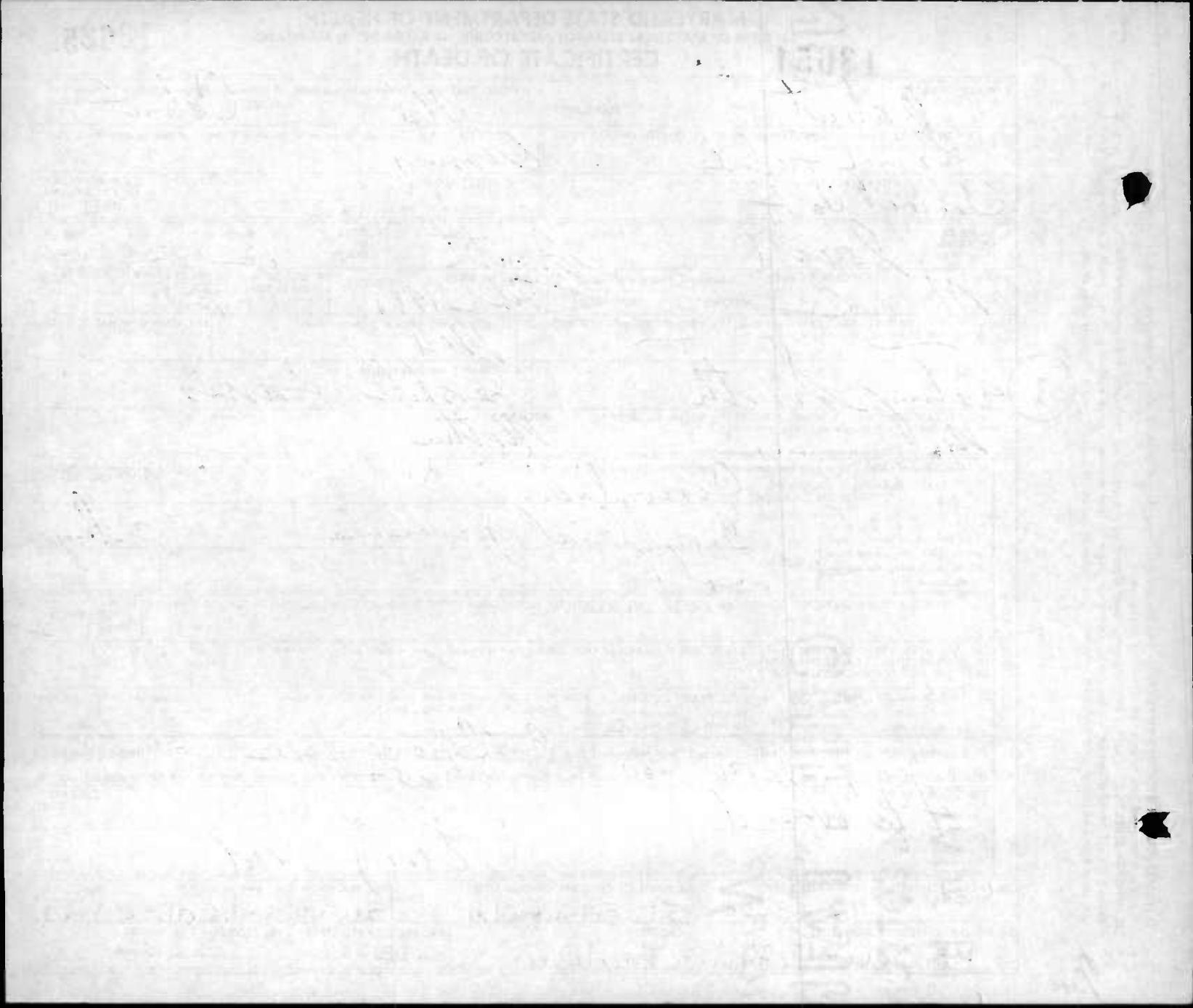
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13625

13651

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>Summer</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co H</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Summer</i>	
3. NAME OF DECEASED (Type or print) <i>Donald</i>		First <i>Donald</i>	Middle <i>Smith</i>
4. DATE OF DEATH <i>12 22 1960</i>		Month <i>12</i>	Day <i>22</i>
5. SEX <i>M</i>		Year <i>1960</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Widowed</i>	9. AGE (In years lost birthday) yrs. <i>70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John Smith</i>		14. MOTHER'S MAIDEN NAME <i>Patricia Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Mother</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Convulsions</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <i>Biological pneumonia</i>		DUE TO <i>Old</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Birth 2/10/1920</i> to <i>12/22/1960</i> , that (I) (we) last saw the deceased alive on <i>12/10/20 1960</i> and that death occurred at <i>Calvert</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>H. W. Ward</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/22/60</i>
22c. PHYSICIAN'S NAME (Type) <i>H. W. Ward</i>		22d. ADDRESS <i>Summer</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-23-60</i>		23b. DATE THEREOF <i>12-23-60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Edmunds</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. F. Jewell, Prince Frederick,</i>		ADDRESS <i>2064 359 X 6</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 29 '60</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles S. Kinney</i>



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13652 13626

1. PLACE OF DEATH a. COUNTY CALVERT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 4 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				
3. NAME OF DECEASED (Type or print) Henry		d. STREET ADDRESS 1				
3. NAME OF DECEASED (Type or print) Henry	First R	Middle Re	Last Wood			
4. DATE OF DEATH December 13 1960	Month December	Day 13	Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1899			
9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Wood		14. MOTHER'S MAIDEN NAME R. Virginia Denton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?				
17. INFORMANT Mrs. Harry Conner, Prince Frederick, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450-1 DUE TO Acute pulmonary edema -						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Heart failure						
(c) DUE TO Congestive heart failure						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 12/10 1960	(County) 12/13 1960	(State) Prince Frederick, Md.
21. I certify that (I) (this hospital) attended the deceased from 12-13 1960 , to 12/13 1960 , that (I) (we) last saw the deceased alive on 12-13 1960 , and that death occurred at M , from the causes and on the date stated above.				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) R. De VILLARREAL, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS St. Leonard, Md. 12/13			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery	23d. LOCATION (City, town, or county) Parsonage Calvert Co. Md.		
24. FUNERAL DIRECTOR'S SIGNATURE A. H. Nease, Jr., Mutual, Md.		ADDRESS	25a. REC'D BY REGISTRAR DEC 19 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Krause		

85-101